

# Mood Disorders in Children and Teens

## Identifying Appropriate Medications and Treatment Is Crucial to Recovery

by **Shalene Kennedy, M.D.**

Mood disorders affect one in every five young people at any given time. The spectrum of disorders ranges from simple sadness to major and manic depression. Mood disorders can disrupt children's and teenagers' daily functioning at home, at school and in the community.

There are many types of mood disorders. For this article, we'll discuss dysthymia (mild depression) and major depression (unipolar depression) — the most common mood disorders affecting children and teens. We'll also highlight the identifying factors of bipolar disorder (manic depression), which is less likely to occur in youth.

### **Who's Affected**

Like other illnesses, depression comes in various forms. Symptoms, severity and persistence vary. Before puberty, boys and girls are equally likely to develop depressive disorders. After age 14, however, females are twice as likely as males to have major depression or dysthymia. The risk of developing bipolar disorder remains approximately equal for males and females throughout adolescence and adulthood.

Young people who have depressive disorders are at an increased risk for illness, substance abuse and, in severe cases, suicidal behavior. Children and teens who have a family history of depression — particularly a parent who had depression at an early age — are more likely than others to experience depression.

Early diagnosis and treatment is critical to recovery; therefore, it's important that families and physicians know the difference between mood swings typical of a child's or teen's particular developmental stage and behaviors that indicate mental illness.

By knowing the symptoms of depression and how to treat the disorder, primary-care physicians and pediatricians may be able to provide care in their practices. For severe cases of depression, physicians may want to refer patients to a psychiatrist or other mental-health professional.

### **Major Depression**

We'll discuss major depression in children and teens first, because some of the symptoms — and treatment recommendations — are the same for this disorder as they are for dysthymia.

Major depression affects one in every 10 young people at any given time — 2 percent of prepubertal children and up to 8 percent of adolescents. Although the recovery rate from a single episode of major depression in children and adolescents is quite high, episodes are likely to recur.

The duration of episodes of major depression is about seven to nine months. About 90 percent of children and teens with major depression reach remission 18 months to two years after onset; about 50 percent of youth diagnosed with dysthymia still have symptoms of the disorder at this point.

The defining features of major depression in youth are the same as they are in adults. For several reasons, however, recognizing and diagnosing the disorder in children and teens may be more difficult. The way symptoms are expressed varies with the developmental stage of the child or teen. For example, young people who suffer from depression may have difficulty articulating their emotions or moods. Instead of communicating how bad they feel, they act out, which could be interpreted as misbehavior or disobedience.

### **The Symptoms of Major Depression**

A child or teen with major depression can have all or some of these symptoms:

- Persistent sadness
- Irritability
- Loss of interest in activities once enjoyed
- Significant change in appetite or body weight
- Abnormal sleep patterns
- Loss of energy
- Feelings of worthlessness
- Difficulty concentrating
- Recurrent thoughts of death or suicide

## CASE STUDY

A.J. is a 9-year-old male who was brought to a psychiatrist by both biological parents for evaluation of behavioral difficulties and irritability. Although the parents were in the midst of a divorce, they seemed amicable, and both had similar concerns about A.J.

A.J.'s parents described him as a pleasant and easygoing child. They noted that, when his parents separated in second grade, A.J. began defying teachers and having altercations with other students. His grades began to slip, and he started having difficulty sleeping — waking up sometimes four times per night. He became particular about what he ate. He dropped out of soccer and Boy Scouts and lost interest in his after-school play dates.

After two months of therapy, A.J.'s therapist recommended he be evaluated for medication. The therapist was prompted to make this decision because A.J. began to make statements such as, "I wish I'd never been born," "I'm stupid," and "I hate myself." He complained of stomachaches and headaches, causing him to miss school. A.J.'s pediatrician found no cause for the physical complaints. In addition, two maternal relatives — closely related — had depressive disorders.

When evaluated, A.J. cooperated reluctantly, avoided eye contact, and appeared lethargic. He rated his mood at three out of 10, with 10 being the best he'd ever felt. He was clearly dysphoric. He articulated having a passive death wish, but no true suicidal ideation or plan. He didn't admit to a current desire for self-injury, but he had cut his wrists about two months earlier.

The psychiatrist recommended continued individual and family therapy. A.J. was put on 50 mg. per day of Trazodone™ to help him sleep and on 10 mg. per day of Celexa™ to enhance his mood.

At his six-week visit, A.J. rated his mood at five out of 10. He said his sleep had improved. A.J.'s parents noticed improvement in their son's mood and attitude, and he was more willing to go to school. He denied any death wish. The dosage of Celexa was increased to 20 mg. per day.

At 12 weeks, A.J. rated his mood at eight out of 10. He had made up missed homework and pulled his grades up. He was sleeping well and beginning to socialize more. A.J. also was considering soccer camp for the summer. A.J. will see his psychiatrist every three to four months until the one-year anniversary of beginning treatment.

Five or more of these symptoms must persist for two or more weeks before a diagnosis of major depression is indicated.

Children and teenagers who are experiencing major depression might isolate themselves socially and have outbursts of shouting or crying. They also might complain of headaches, stomachaches or feelings of tiredness. It's fairly common for young people who are depressed to have a fear of — or preoccupation with — death. For example, they may articulate that "life isn't worth living." Knowing whether a person has a specific plan to carry out a suicidal thought can help in determining the severity and intensity of the depression.

In 1997, suicide was the third-leading cause of death in 10- to 24-year-olds. The National Institute of Mental Health (NIMH) estimates that, among children and teens who have major depression, as many as 7 percent attempt suicide. The risk is even greater in boys and those who abuse drugs or alcohol.

### Diagnosing Major Depression

Various screening tools enable physicians and mental-health professionals to assess whether a patient has a mood disorder — and, if so, how severe the disorder is. These tools include *The Children's Depression Inventory* (for youth ages 7 to 17) and the *Beck Depression Inventory* (for adolescents). On the Beck inventory, for example, a score below 15 could indicate mild depression; a score of 15 to 30 is a sign of moderate depression; and a score of more than 30 suggests severe depression.

Along with the screening, physicians should conduct structured clinical interviews with the patient, the parents and — when appropriate — the patient's teachers and school social workers to get feedback on the youth's symptoms and behaviors.

### Treating Major Depression

The treatment for major depression and dysthymia typically includes psychotherapy and selective serotonin reuptake inhibitors (SSRIs). Common SSRIs are Celexa™, Paxil™, Prozac™, and Zoloft™. The dosages and duration of use depend on patients' clinical symptoms. It must be noted, however, that recent reports — including one in the April 24, 2004, issue of *The Lancet* — question the safety of Paxil, Zoloft, Effexor and Celexa in children who are suicidal. A copy of this article is available at <http://www.thelancet.com>.

Physicians and therapists can refer to the *Child and Adolescent Clinical Pharmacology* textbook by Wayne Hugo Green for additional information on medications for treating youth with mood disorders.

A recent NIMH-supported study shows that psychotherapy — particularly cognitive-behavioral therapy (CBT) — led to remission in nearly 65 percent of major and mild depression cases. The premise of CBT therapy is that people with depression have distorted views of themselves, the world, and the future. CBT — designed to be time-limited therapy — focuses on changing these distortions.

Continuing psychotherapy for several months after remission of symptoms may help patients and families cope with the aftereffects of depression, address environmental stressors, and understand how a youth's thoughts and behaviors could contribute to a relapse.

### Dysthymia

Dysthymia is a less severe, yet typically more chronic, form of depression. Dysthymia is diagnosed when a depressed mood persists for at least a year in children and adolescents and is accompanied by at least two other symptoms of major depression. Dysthymia typically doesn't disable people, but it keeps them from functioning well or feeling healthy. Many young people with this disorder also experience major depressive episodes.

#### Symptoms of Dysthymia

Children and teens with dysthymia are in a depressed or irritable mood for most of the day — for more days than not when others observe them — for one year. They also have at least two of the symptoms of major depression, such as poor appetite or overeating, insomnia, fatigue or poor concentration. They also might experience feelings of hopelessness. Although these symptoms are less severe than are those in a major depressive disorder, the chronic nature of dysthymia can severely impair a child's or teen's development.

#### Diagnosing Dysthymia

As noted in the major depression section, physicians and mental-health professionals should use the *Children's Depression Inventory* and the *Beck Depression Inventory* to screen for depressive disorders. Physicians should also conduct structured clinical interviews with the patient, parents and others who have regular interaction with the patient.

#### Treating Dysthymia

Treatment for dysthymia may prevent more serious depressive disorders from developing. For some patients, psychotherapy is successful. Other patients need a combination of therapy and medications to manage their disorder. The common medications used are the same for treating major depression. Again, the dosages and duration of use depend on patients' clinical symptoms.

### Bipolar Disorder

Bipolar disorder, also called manic-depressive illness, is not nearly as prevalent in children and teenagers as it is in adults. Bipolar disorder is characterized by cycling mood changes: severe highs (mania) followed by deep lows (depression). Sometimes the mood switches are dramatic and rapid, but most often they are gradual.

When in the depressed cycle, people with bipolar disorder can exhibit all of the symptoms of a depressive disorder. When in the manic cycle, people might be over-active, over-talkative, and extremely energetic. Mania often affects thinking, judgment, and social behavior in ways that cause serious problems and embarrassment. For example, someone in a manic phase may feel elated, full of grand schemes ranging from unwise school and relationship decisions to spending sprees. Mania, left untreated, may advance to a psychotic state.

Because of the seriousness of this disorder, physicians should refer youth who are diagnosed with or suspected of having this disorder to a mental-health professional for evaluation and treatment.

### Is It Depression?

Many medical disorders mimic depression. Therefore, physicians — depending on a patient's physical exam and medical history — should order laboratory studies to rule out certain medical conditions. Consider the following baseline laboratory studies:

- A complete blood cell count, with differential, to rule out anemia or infection
- A determination of electrolyte creatinine levels, to rule out electrolyte disorders or renal disease
- Liver function studies, to rule out hepatitis and drug effects
- Thyroid function tests, to rule out thyroid disorders
- An electroencephalogram, to assist in ruling out a seizure disorder

### When to Refer

Depending on a patient's clinical symptoms, some physicians may elect to treat patients in their practices. Working closely with mental-health professionals (pediatric psychiatrists, psychologists, counselors, and social workers), however, is essential to managing mood disorders in children and teens. Patients who are suspected of having bipolar disorders should be referred to a psychiatrist.

Given the lifetime and familial nature of these disorders, family physicians are in a good position to screen, treat, and monitor these patients and to refer them when appropriate.

## Author's PROFILE

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Shalene Kennedy, M.D., is a pediatric psychiatrist at Gillette Children's Specialty Healthcare. She also practices at Psychiatric Recovery in St. Paul, Minn., Scott County Mental Health Center in Shakopee, Minn., and Boys Totem Town juvenile correctional facility in St. Paul. Kennedy specializes in treating children and young adults with severe behavioral and emotional disturbances.

Kennedy received a bachelor's degree in biology from Creighton University in Omaha, Neb., and a doctorate of medicine from the Creighton School of Medicine. She completed a general psychiatry residency at Mayo Graduate School of Medicine in Rochester, Minn., and a fellowship in child and adolescent psychiatry at the University of Minnesota.

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*A Pediatric Perspective*  
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200 University Avenue East • St. Paul, MN 55101  
651-229-1744

Editor-in-Chief.....Steven Koop, M.D.  
Editor.....Beverly Smith-Patterson  
Designer.....Kim Goodness  
Photographer.....Anna Bittner

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Gillette will open a new outpatient clinic in June in Burnsville, Minn., a Twin Cities south-metro suburb. The clinic will offer evaluations and treatment for children and teens who have cerebral palsy, torticollis, cleft lip and palate, speech and motor delays, orthopaedic conditions, and other complex medical needs.

Burnsville patients will have access to a rehabilitation center and various ancillary services, including assistive technology, casting, radiology, psychology, and spasticity-evaluation clinics.